acne a built in skew-factor has been added which does the subject matter of the title a gross injustice.

This "tunnel-vision" view of dermatologic radiotherapy leaves untouched the many other skin diseases, dermatoses and tumors for which radiotherapy may be and often is used with good results. This is a vast subject and even vaster is the use of dermatologic radiotherapy in the treatment of malignant skin lesions. Only after adequate inquiry into attitudes and practices in these and related fields such as the use of grenz ray therapy for benign dermatoses can one draw any conclusions about the death or survival of dermatologic radiotherapy.

I join Doctor Epstein in decrying the lack of training which has become the vogue in many residency programs. Even sadder is the emergence of third parties in the form of malpractice insurance carriers as arbiters of medical decisions in the choice of therapies. I, too, am a victim of the "pulled plug syndrome" having opted to discontinue the use of grenz and x-ray therapy rather than pay thousands of additional dollars in premiums to have available an infrequently used modality which was not paying even the fees to cover the annual premiums.

J. DAVID BRAYTON, M.D.
Assistant Clinical Professor
Dermatology
L.A. County-USC Medical Center

The Author Replies

I doubt if Dr. Brayton's criticisms are significant. The treatment of acne is the prime indication for the control of benign dermatoses with x-radiation. Grenz rays is an entirely different situation because of the softness of these rays. Its minor absorption eliminates most of the alleged hazards of x-radiation therapy—including leukemia, genetic damage, thyroid cancer, shortening of life, etc. This survey shows definitely that the interference in training in dermatologic radiotherapy dooms this modality.

ERVIN EPSTEIN, M.D.
Oakland

DRUGS FOR TACHYARRHYTHMIA IN PATIENTS WITH MYOCARDIAL INFARCTION

Lidocaine is best given as a bolus of 50 mg and then given as an infusion of 1 to 2 mg per minute. If you start lidocaine infusion in a patient with ventricular ectopic beats in the first 24 hours after myocardial infarction and arrhythmia recurs, it is worthwhile not to increase the infusion rate but rather to give another bolus. Increasing the infusion rate to 3, 4, or 5 mg per minute sometimes leads to drug toxicity without subduing the arrhythmia. . . . .

Lidocaine is effective in about 80 percent of patients who have multiple ectopic beats. In the remaining 20 percent, it will fail. The drug of second choice, in my view, is procaine amide. To control recurrent ventricular arrhythmias, this agent should be given in doses of anywhere from 250 to 500 mg to as high as 1 gram every three hours. It's rapidly dissipated.

If procaine amide is not effective, if the patient has many ventricular ectopic beats and the rate is 60, sometimes by raising the rate to 70 or 80 with atropine, you'll find that lidocaine becomes very effective or it may not even be required.

—BERNARD LOWN, M.D., Boston
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